



# MASSACHUSETTS

Harvard University Student Health Program - 75 Mount Auburn Street - Cambridge, MA 02138

Member Name: \_\_\_\_\_

BCBS ID: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Certification of Eligibility for Medicare

Please check the boxes that describe your situation.

☒ I hereby certify that I am actively working more than 20 hours per week and enrolled in my employer's group health insurance.

**I hereby certify that I am enrolled in Medicare as of the following dates:**

☒ Medicare Part A Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

☒ Medicare Part B Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**I hereby certify that I am not eligible for Medicare due to the following reason(s):**

☒ I am not eligible because neither my spouse nor I earned the qualified quarters of coverage for Social Security, for the Railroad Retirement Board, or as a government employee

☒ I am not eligible because I am not a U.S. citizen or a U.S. permanent resident

☒ Other – Please provide a detailed explanation

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the information I have supplied is true and complete.

\_\_\_\_\_  
Subscriber/Member Signature

\_\_\_\_\_  
Date